Testimony of

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on

A Medicare Prescription Drug Safety Net:

Creating A Targeted Benefit for Low-Income Seniors

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Good morning, Mr. Chairman and Members of the Subcommittee. My name is Tom Miller. I am director of health policy studies at the Cato Institute. It is a pleasure to appear before you today to examine whether current proposals to create a Medicare prescription drug benefit do enough to address the needs of low-income seniors and whether an MSA-like benefit tied to a catastrophic insurance policy and targeted to low-income and indigent seniors would be a more cost effective solution.

In brief, both H.R. 1 and S. 1, the two bills providing a Medicare prescription drug benefit that were approved by the House and Senate, respectively, earlier this year failed to target their assistance to those seniors in greatest need. Both bills squandered scarce resources by focusing on subsidizing the discretionary, early-dollar drug expenses of upper- and middle-income seniors.

H.R. 1 and S. 1 also failed to provide a credible and effective route to comprehensive, market-based reform of the overall Medicare program. Such reform would expand the availability of a wider variety of competitive, affordable choices of drug benefits within integrated packages of linked benefits that would provide the greatest value by coordinating trade-offs between drugs, surgery, hospitalization, and outpatient care options.

In the absence of serious, sustainable reform provisions within whatever is likely to emerge, finally, from the current House-Senate conference committee later this fall, a better alternative would be to do more by doing less. A far simpler combination of a limited drug-discount card, additional financial assistance to low-income seniors, and a very modest catastrophic-coverage benefit delivered by competing private sector entities actually would solve the key problems of access to necessary drugs. It also would avoid causing further damage to future Medicare reform efforts, to our overall health care system, and to the deteriorating balance between our available resources and the increasingly overstretched commitments to capture more of them within the federal budget.

In pursuing the alternative of a more narrowly targeted interim drug benefit with second-best limits and safeguards against the political dangers even it may pose, we should be careful not to undermine market-based incentives to control catastrophic-level drug costs. Instead of providing relatively open-ended subsidies for such protection and delegating key financial and administrative decisions to Medicare program managers, we should instead place direct control of subsidized dollars for limited drug coverage in the hands of eligible Medicare beneficiaries and then, through

open competition, encourage at-risk private insurers to offer higher-value catastrophic protection to them.

An MSA-like account could provide the vehicle for eligible seniors to receive and accumulate funds to afford such purchases.

In most private insurance options, the price protection of negotiated rates could be passed down to out-of-pocket purchases remaining below the catastrophic stop-loss level. Straightforward high deductibles are administratively simpler and provide better economizing incentives than multiple tiers of coinsurance rates and co-payments. Beneficiaries spending more of their own money, of course, could adjust the initial shell of such coverage to provide more customized options. Initial deductible limits also could be adjusted to target additional layers of subsidized insurance coverage to those seniors facing the most difficult medical and financial challenges.

We should retain a sense of perspective in the midst of a too-often overheated Medicare drug-benefit debate. More than two-thirds of all Medicare seniors currently have some version of prescription drug coverage, and perhaps as many as three-fourths of them do under the broadest definitions of "coverage." Average out-of-pocket drug spending costs for all Medicare beneficiaries this year is estimated to be about $1000. But the

skewed nature of drug spending among Medicare seniors also means that nearly one-third of all out-of-pocket drug spending will be incurred by a much smaller number of beneficiaries – the 5 percent of beneficiaries with annual out-of-pocket expenditures above $4000. Subsidizing the early-dollar drug purchases of most Medicare beneficiaries would leave fewer funds available to assist other, more financially stressed seniors with multiple chronic conditions that require more expensive, longer-term drug therapy.

The sustainability of the overall Medicare program, as well as the future quality of life for younger workers and their families, remains at stake, too. Non-seniors need to finance their own health insurance, educate their children, and save for retirement. In addition, a generous Medicare drug benefit that overreaches available financial resources will surely trigger broader government price controls on drug makers and threaten to choke off access to the vast sums of capital and skilled manpower needed for the next round of lifesaving drug research and development.

In short, we need to walk more slowly and carefully instead of racing ahead blindly. The fundamental solution is to reform the overall Medicare program and allow seniors to determine the best uses of the taxpayer subsidies dedicated to them. Until politicians decide to step up to that task,

it may well be that the best we can do is provide limited assistance to those seniors with the greatest drug expenses, along with more limited financial protection for uninsured seniors who otherwise will face the highest list prices for drugs when they purchase them on an out-of-pocket basis.